BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

GROUP PLACEMENTS OF CHILDREN WITH RHEUMATIC INFECTIONS

A STUDY OF GROUP PLACEMENTS MADE BY THE CHILDREN'S MISSION TO CHILDREN IN THE SUMMER OF 1938

A Thesis

Submitted by

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INTRODUCTION

Purpose

The purpose of this thesis is to present a picture of the summer group placements made by the Children's Mission to Children for a seven week period in 1938. The placement of rheumatic children with relatively serious heart conditions in groups, to simulate a camp environment, was undertaken as an experiment in treatment by the Children's Mission. An effort will be made to study the program of care and activities offered in each of the foster homes used, the relation of these activities and care to the welfare of the children, the social and physical gains, if any, observable in the children, and the part the placement played in giving both the parent and child a more complete understanding of the latter's condition and care needed for this.

Each patient in the group studied had an active or inactive rheumatic infection. The author wishes to learn to what extent the group placement helped the patient and his parents, who visited him often, better to understand his condition and the kind of care he required; as well as to determine the actual physical gains made and their duration.

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INTRODUCTION

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Such a study is of significance because of the prevalence of rheumatic infections among school children throughout the United States. This is especially true of the eastern section of the latter states where the climate

is damp and cold. If it can be shown that additional group placements such as those made in 1938 will prevent recurrence of the disease throughout the following school year, placements of this kind may be considered a preventive measure in the treatment of recurrent rheumatic infection.

Since this program was undertaken as an experiment, it is important to determine, after six years, its real value to the children placed. If it is found to be successful, it would point to continued experimentation of group placement of children with relatively serious heart conditions.

Group placements in this study may be defined as the placement of ten or more children together in order to create as nearly as possible a normal camp environment.

These group placements for the summer of 1938 were chosen because they represented a particular unit with medical follow-up on each patient by the referring hospital. Because of this, a long term as well as an immediate evaluation of the placements may be made.

Method

The descriptive method has been used in presenting a picture of the camp settings in which the children were placed and the case method in presenting a picture of the children who received care.

Sources of Information

The author used the medical and social records of the children and the foster home records of the Children's Mission to Children as the primary sources of information. In addition to this, unpublished material on the

history of the Children's Mission as well as material dealing with the group placement project was used. Previous and follow up medical histories of the children were obtained from the referring agencies. To obtain further information about the foster homes, the buildings used were visited, two of the foster mothers were interviewed, and reports made by the foster mothers were read.

The author has also read several books and articles concerning convalescent placement of children and rheumatic conditions as manifest in children.

In addition, various members of the staff of the Children's Mission to Children gave the author much helpful information in personal recollections and experiences with the summer placements of 1938.

CHAPTER II

RHEUMATIC INFECTIONS

Rheumatic fever is becoming a public health menace in the United States, particularly in the New England and North Atlantic areas. In several states it has become a reportable disease under a ruling by the local department of public health.[1] Examination of data compiled from the Federal Census reports of 1941 will reveal the importance of increased public consideration of the growing problem of rheumatic infections. Since rheumatic fever is primarily a disease of childhood and early adult life, enumeration of figures for deaths of children from five to fifteen years of age reveal its importance. In this age group, four hundred and ninety-seven deaths per ten thousand are recorded as being due directly to acute rheumatic fever. In addition to this figure, eighty-five per cent of deaths from diseases of the heart may be considered rheumatic in origin. This is a generally accepted fact, that nearly all heart disease in children is caused by a previous attack of rheumatic fever. This totals well over eighteen hundred deaths pere ten thousand due to rheumatic infection. The next largest cause of death is pneumonia, which also includes influenza. The figures for deaths from this disease are about seventeen hundred per ten thousand. Rheumatic fever continues to be a serious threat to children of high school age, as well, accounting for an estimated fifteen hundred

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1 T. Duckett Jones, Rheumatic Fever in Children, p. 1.

deaths per ten thousand in the age group fifteen to nineteen. Tuberculosis is the leading cause of death in this group with an estimated rate of three thousand two hundred fifty-seven deaths per ten thousand in the year 1941.[2]

With this tremendous toll of life among children and young people, it becomes increasingly important that curative as well as preventive methods of care be undertaken. The first step in either of these methods is an understanding of symptoms, basic causes, and care needed by those who now have or may develop rheumatic infection.

The word "rheumatism" is used freely without very careful discrimination as to its actual meaning. Rheumatism as a category of disease may be divided into two groups, classified according to causes. One type is due to bacteria or its poisons and is the so-called infectious form of rheumatism. The second type is due to a chemical change in the body and is the so-called chemical form of rheumatism. The former type is the most common today and has been known as long as there have been written records.[3] Accurate descriptions of both types of rheumatism may be found in the writings of the early sixteenth century. Mention is made in the writings of early Greek and Roman physicians of diseases with symptoms very much like those of rheumatic infections.[4]

Of the infectious type of rheumatism, rheumatic fever, chorea and rheumatic heart disease are the chief manifestations. It is thought that chorea and rheumatic heart disease are secondary infections because they

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2 Betty Huse, "Rheumatic Fever in Childhood," The Child, 7:158, May, 1944.

3 Roger I. Lee, Health and Disease, p. 295.

4 Ibid., p. 295.

appear to follow an attack of rheumatic fever. The seriousness of chorea and rheumatic heart disease, however, does not seem to be in direct proportion to the seriousness of the rheumatic fever attack, the latter often being very light, requiring, it seemed, little specialized care. However, in such a case the rheumatic infection remained to appear later in another form.[5]

The symptoms of rheumatic fever are joint pains, tenderness, swelling, heat and redness, muscular aching, fever, chills, sweating and general weakness, effort syndrome and general malaise, loss of weight, and lack of natural color. The so-called "growing pains" of childhood are often found to be evidence of rheumatic fever.[6]

Chorea may occur after an attack of rheumatic fever or simultaneously with it. Its symptoms are nervous manifestation, uncontrolled shaking of the extremities, and, in the more severe cases, uncontrolled movements of the facial muscles. In this particular rheumatic manifestation, the rheumatic organism infects the nerve centers in various parts of the body, resulting in a more or less obvious degree of disease.[7]

The symptoms of rheumatic heart disease depend upon several factors, the activity of the infection, the strength of the heart, and the lesions of the heart. The infective agent may attack the heart valves or heart muscles, thus impairing heart function. Each subsequent attack will increase damage to the heart and the greater the heart injury the less able

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5 Ibid., p. 299.

6 Paul D. White, Heart Disease, p. 331.

7 Mary C. Bancroft, Pediatric Nursing, p. 443.

it is to carry on its function. An attempt to compensate for injury is made by the heart and is shown through increased pulse rate and elevation of blood pressure. Symptoms of rheumatic heart disease are enlargement of the heart, irregular rhythm, and heart murmurs. In more severe cases of rheumatic heart disease, there are cutaneous or sub-cutaneous manifestations known as rheumatic nodules or skin lesions. The chief of these are pebble-like formations found beneath the tendrom sheath or joint capsule of the skull, elbows, knees, fingers, ankles, wrists and other similar places in the body. These vary in size from a pin-head to a pea and tend to appear singly or in crops. They may last for a few days, several weeks, or even months. Although considered to be a symptom of disease, all other things being equal, they may be considered as a favorable reaction to the disease on the part of the patient.[8]

The study of the heart shadow is of little help in diagnosing rheumatic heart disease and the electrocardiograph is often normal in spite of the presence of heart injury. The blood and urine are frequently abnormal when there is active disease. A high white count in the blood is often found in case of severe infection, and it has been found that slight secondary anemia is common among children with rheumatic heart disease. The sedimentation rate of the blood, used as a measure of activity for all manifestation of bacterial rheumatic infection, increases in proportion to the activity of the infection.[9]

Despite intensive research, the exact cause of bacterial rheumatic

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8 White, op.cit., p. 333.

9 Ibid., p. 334.

infection, so-called to distinguish it from that caused by chemical changes in the body, is unknown. Some believe it to be of streptococcus origin; some go so far as to say that the hemolytic streptococcus is the agent responsible. Still others believe it to be a filterable virus. No specific immunity is built up following the first attack and some authorities believe through studies made that hereditary factors may render some individuals susceptible to it. Rheumatic infection has a relatively high family incidence. No definite contagious elements have been isolated, but it is felt that family incidence may be due to similarity of environment and living conditions inducing respiratory infections.[10]

Dr. Jeans presents an interesting point of view as to the susceptibility of a person to rheumatic infection. Although the author of this study has found no other authorities concurring in this opinion, it would appear that it is worthy of note.

He believes that as a result of the chronic focus of infection or repeated acute infections, the body becomes sensitized to the rheumatic organism. Continued or repeated infection after sensitization leads to an allergic response varying in nature and degree according to the degree of sensitization. He states that before sensitization, upper respiratory infections have only local effect, but that after sensitization a rheumatic recurrence may easily develop from an upper respiratory infection.[11]

He, of all the authorities investigated by the author, does not believe that the focus of infection is primarily the mouth and nose. He feels

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10 Bancroft, op.cit., p. 442.

11 Philip C. Jeans, Essentials of Pediatrics, p. 454.

rather that the causative organism is present in the blood stream at the time of infection and that it reaches various sites throughout the body by means of the blood stream.[12]

Dr. Williams believes strongly that diseased tonsils are a major factor in susceptibility to rheumatic infection. He states that research has shown, "that in four-fifths of the cases of rheumatic fever, tonsillitis precedes or accompanies the disease." He also refers to the work of Dr. William St. Laurence and his findings to the effect that, of ninety-four cases of rheumatic infection after tonsillectomy the recurrence of rheumatic manifestations dropped from eighty-five to slightly over thirty per cent. Dr. Williams believes that the tonsils are the most important single point of entry for the infecting organism.[13]

Dr. Bancroft, however, is not as optimistic. She states that if tonsillitis has occurred before the manifestation of rheumatic infection, a tonsillectomy may be indicated. However, she believes that the relation of diseased tonsils to rheumatic infection is not clear and that too startling results must not be expected from the tonsillectomy in preventing the occurrence or recurrence of rheumatic infection.[14]

Dr. White states that the older the patient when the disease is contracted the less damage to the heart, while the younger the patient the more the heart suffers from the infection.[15]

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12 Ibid., p. 454.

13 Jesse F. Williams, Personal Hygiene Applied, p. 384.

14 Bancroft, op.cit., p. 444.

15 White, op.cit., p. 331.

It is accepted by almost all authorities, however, that the nose and throat are important if not the most important points of infection.

The extent of rheumatic infection throughout the country can be seen by the fact that it has been conservatively estimated that there are one million people in the United States today with rheumatic heart disease alone. This causes some forty thousand deaths annually. In the New England states it is estimated that one per cent of the school children have rheumatic fever.[16]

Among children seven to ten years of age, rheumatic infection causes more deaths than any other disease. It ranks high as a disabling disease as well as a cause of death. It is of especial importance to consider this disease in relation to childhood since it usually begins in this period of life. Early recognition and proper management of the disease at this beginning stage is very important.[17]

Rheumatic infection appears to be rare in the first year of life. Dr. Jeans uses this fact as one of the proofs of his theory of allergy, since the development of an allergy usually requires about a year following birth. The earliest age at which rheumatic infection is at all prevalent is at two years of age. The peak of its incidence is reached among children seven to ten years of age. It rarely appears for the first time after puberty.[18]

Climate and poor living conditions apparently are very important predisposing factors in rheumatic infection. The disease is most prevalent in

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16 Metropolitan Life Insurance Company, About Rheumatic Fever, p.2.

17 Jeans, op.cit., p. 455.

18 Ibid., p. 455.

the temperate zone where rather rapid changes in weather occur. Dampness and darkness also appear to be predisposing factors. The real public health aspects of rheumatic infection may be seen from the fact that better housing, more consistent medical care of children, and the teaching of hygienic methods would help to a great extent to prevent rheumatic infections.[19]

The chief precautions against rheumatic infection are good personal hygiene, frequent medical examinations, proper treatment of foci of infection, as diseased tonsils, abscessed teeth, infected sinuses,[20] and a program of rest, play, sunshine and nourishing food to maintain the health of the children at the highest possible level.[21]

There is general agreement among authorities as to the care given children suffering from rheumatic infections. The first emphasis is upon complete bed rest during the active stage of the disease. This is followed by slowly increasing activity as the infection subsides. The second emphasis is upon nourishing food to help the child gain strength to combat the disease. In addition to these two basic rules for care, there are several procedures which help to alleviate local irritation. Joint pain and swelling may be greatly relieved by the administration of sodium salycilate or aspirin. Particularly painful joints may also be wrapped in cotton and local application of oil of wintergreen seems to be of some value.[22]

The most important part which the physician plays in giving treatment

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19 Bancroft, op.cit., p. 442.

20 Metropolitan Life Insurance Company, op.cit., p. 3.

21 Williams, op.cit., p. 365.

22 Jeans, op.cit., p. 458.

for rheumatic infection is diagnosing the disease correctly and recognizing when it has passed from the active to the inactive stage. It is only when the disease has been inactive for an extended period and thus quiescent that the child may return to the full amount of activity recommended for his capacity.[23]

Children with rheumatic infections, particularly rheumatic heart disease, are often treated as cripples and referred to as, "the cripples who do not limp". Nothing could be more detrimental to the child. It is the emphasis upon his capacity rather than his limitations which will help him become a happy and well adjusted child and adult.[24]

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23 T. Duckett Jones, op.cit., p. 7.

24 Metropolitan Life Insurance Company, op.cit., p. 3.

CHAPTER III

HISTORY OF THE CHILDREN'S MISSION TO CHILDREN

Boston of the 1840's offered no wholesome recreational facilities to the underprivileged children of the City. Nine year old Fannie Merrill, on her way each Sunday to Pitts Street Church, now Bulfinch Place Chapel, observed this. She felt that the Unitarian Sunday Schools might join in helping these children, and suggested to her father that this might be done. Acting upon her suggestion, he gained the support of others in the Church and in 1849 the Children's Mission to the Destitute Children of Boston was founded. A small building was rented in the Kneeland Street section of Boston and under the direction of Reverend Joseph E. Berry a missionary program was started. This was offered as a daily program of Bible stories and games to all children of the area, regardless of religious affiliation.[1]

By 1858, a large hall was rented because of the increasingly greater number of children served by the program. At this time, also, a sewing circle of the ladies of the Pitts Street Church affiliated itself with the Mission and provided many needed articles of clothing. It was in this period that children's agencies in the East were following the practice of collecting homeless children and sending them to western churches to be placed indiscriminately with people who offered to take children. Six such groups

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1 Parker B. Fields, Outline History of the Children's Mission (unpublished), p. 1.

CHAPTER III

HISTORY OF THE CHILDREN'S MISSION TO CHILDREN

Because of the 1850's offered no wholesome recreational facilities to the underprivileged children of the city. Miss Jane Ann Purcell, another early social worker to Fifth Street Church, was Sullivan Place Chapel, observed this. She felt that the Reverend Dudley Sargent might help in helping these children, and suggested to her father this might be done. Acting upon her suggestion, he gained the support of others in the Church and in 1858 the Children's Mission to the Destitute Children of Boston was founded. A small building was rented in the Rowland Street section of Boston and under the direction of Reverend George S. Perry a missionary program was started. This was offered as a daily program of Bible stories and games to all children of the area, regardless of religious affiliation.

By 1868, a large hall was rented because of the increasingly greater number of children served by the program. At this time, also, a sewing circle of the ladies of the Fifth Street Church affiliated itself with the Mission and provided many needed articles of clothing. It was in this period that children's agencies in the East were following the practice of sending homeless children and sending them to western churches to be placed indiscriminately with people who offered to take children. This was known

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1 Parker S. Fields, Outline History of the Children's Mission (unpublished), p. 1.

were sent under the sponsorship of the Children's Mission but it was soon realized that the practice had little to commend it and it was discontinued.[2]

The 1850's saw the establishment of a small home for homeless boys. It, too, was soon discontinued because it was found that most of the homeless boys were runaways who were not really in need of the permanent care offered.[3]

Although these two plans for more permanent care of children proved to be unsuccessful, the idea persisted until the building of a home in 1864. At this time also the Children's Mission became incorporated. In 1872 the home building was dedicated. As the care of children in this home progressed, adoption became an important part of the work done. This building, accommodating fifty children, became crowded and in 1890 more property adjoining that of the original home was purchased, providing accommodations for fifty additional children.[4]

At the turn of the century, a summer program of transferring all the children in the home in Boston to a large home in the country was adopted. This proved to be especially successful and it was decided to continue this the next summer. The next year it proved to be impossible to rent another large house and, instead, the children were placed with families in the country. This appeared to be a much more natural environment for a homeless child, and the idea of placing children with families for year-round

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2 Ibid., p. 2.

3 Ibid., p. 3.

4 Ibid., p. 4

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2 Ibid., p. 2.

3 Ibid., p. 3.

4 Ibid., p. 4

care gradually took root. Mr. Parker B. Field, who for some years had been assisting Reverend Berry, whose health was failing, became the Executive Secretary of the Children's Mission when these experiments in foster home care were taking place.[5]

In 1907 the policy of the agency changed definitely from that of offering institutional care for an extended period to that of temporary institutional care to be followed by foster home placement. By 1913, it was felt that the services offered were to a larger group than to only destitute children and the name was changed to: "The Children's Mission to Children." The institution maintained by the Children's Mission gradually came to be used as a study home and finally only as an office, children being placed directly in foster homes.[6]

In 1914 the medical phase of foster home care was undertaken at the suggestion of Dr. Richard C. Cabot. In 1905 Dr. Cabot had organized the Social Service Department at Massachusetts General Hospital[7] and through the work of this Department he came to realize the need for care of convalescent children outside the hospital environment. He had suggested a convalescent foster home program to several child placing agencies but had met with little success. The Children's Mission, after much consideration, agreed to do this as an experiment to determine the value of such placements and the need for this care in the community. The plan at that time involved the cooperation of the hospital and the agency - the hospital to provide

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5 Ibid., p. 5.

6 Ibid., p. 7

7 Arthur E. Fink, The Field of Social Work, p. 262.

the physician who had previously followed the child and who would continue medical supervision in the foster home, and the Children's Mission to find the suitable foster home and provide supervision by a social worker. When the program was started, the chief need was for foster home placement of children with orthopedic difficulties, but as clinic facilities in this field developed, a greater need was seen among children with chorea, rheumatic fever, and cardiac conditions.[8]

In 1920 the building which was first the institution and later the general office for the Children's Mission was sold and the office was moved to its present location at 20 Ashburton Place where it occupies the five floors of a colonial building.

The work of the Children's Mission from 1914 until 1934 offered foster home placement and child welfare services in their own homes to both convalescent children and those in good health. After 1934, with the advent of Miss Elizabeth E. Bissell as General Secretary, the convalescent children rapidly became the focus of attention as an increasing need for this specialized care was shown. With the change in emphasis to medical problems, the medical supervision of children placed, gradually has passed from the hospital to the medical staff of the Children's Mission.[9] This is especially true of the medical foster homes which are visited regularly by the Children's Mission physician. In addition to regular visits, the physician examines the children at the time of placement, referral home, and whenever an emergency need arises in the foster home. Except in very unusual cases,

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8 Fields, op.cit., p. 8.

9 Ibid., p. 11.

the only children in medical foster homes not visited by the staff physician are those placed through the Boston Dispensary; these children are visited by Boston Dispensary physicians under District Service. In addition to the physician on the medical staff, there is also a dentist who provides needed dental care. Children who are well enough are taken to his office for treatment, while those too ill to get up receive treatment in the foster home if such a need arises. This dentist has much understanding of rheumatic conditions and the relation of the teeth to these conditions. A laboratory technician visits the medical homes each month to make necessary laboratory tests.

In 1936 research showed that specialization in convalescent care was needed in the community in addition to the work done by several other children's agencies giving general child welfare services. So completely was this accepted, that by 1939 the policy of the Children's Mission had been expanded to accept children with medical problems from any geographical area. This defined the Children's Mission as a real medical agency. The change to a medical problem as a criterion for the acceptance of a case was brought about, in part, by a survey in 1937 to determine the incidence of rheumatic fever, chorea and rheumatic heart diseases in Boston. The results of this survey showed a definite need for facilities providing foster home care as well as revealing the important fact that rheumatic infections were becoming a major health menace in the City.[10]

With the increasing emphasis on cases with a medical problem, definite policies have been developed in home finding, financial responsibilities,

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10 Ibid., p. 12.

intake procedure, and medical supervision. Since the author's emphasis is on care given rather than agency policy, only those policies relating to medical supervision as connected with foster home care will be discussed in the following Chapter.

In summary, the history of the Children's Mission to Children is similar to the history of any child placing agency with one addition. It started as a recreational program, developed into an incorporated agency giving institutional care to homeless children, and from this realized and accepted rather early the value of foster home care and individual attention for a child. By specialization in foster home care of children with medical problems, the Children's Mission has not only developed in the field of child placing but in the medical field as well, in the latter field being recognized and accepted by hospitals throughout the City.

CHAPTER IV

CARE OF RHEUMATIC CHILDREN BY THE CHILDREN'S MISSION TO CHILDREN

Since this thesis is the study of an experiment in group placements by the Children's Mission to Children, the author feels it to be essential to present a picture of the other forms of care given under the agency's program. The following discussion of types of care given may be said to be that for rheumatic infections, since over seventy-eight per cent of the children under care in 1943 had rheumatic fever, rheumatic heart disease, chorea, or a combination of these. Of the three hundred and forty-five in care for the year 1943, three hundred and twelve were medical cases. Of the thirty-two non-medical cases, six were English guest children, and the remainder were special cases which were receiving long-time care or whose quardianship had been given to the agency. These figures show clearly the medical nature of the work of the agency.[1]

The Children's Mission program emphasizes foster home placement with the use of hospital facilities if necessary. In addition, supervision in the child's own home following placement is a large and important part of the total program.

A distinction is made between "medical" and "non-medical" foster homes. The former are homes in which children receive bed care similar to that given in a hospital but in a home-like atmosphere. The foster mothers in

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1 Children's Mission to Children, Annual Report for 1943, p. 3.

such homes have had training as a nurse or experience in nursing.

In such a home environment medical care is given, comprising necessary medications, nourishing food, rest, occupational therapy, religious instruction, and school work.

In addition to the training and experience of the foster mother, the doctor either from the staff of the Children's Mission or the Boston Dispensary, which follows its own cases, examines each child at least once a month. The staff doctor also examines each child when placed and when returned home. A laboratory technician, who is a part-time member of the staff, visits the medical foster homes each month, making the necessary blood tests and other laboratory tests which seem essential. These blood tests help to determine, with other findings made at the time of the monthly examinations by the doctor, the activity of rheumatic infection. A dentist experienced in working with rheumatic children gives necessary dental care. The children are taken to his office, or, if the situation is an emergency, he visits the foster home.

Occupational therapy both for recreation and for therapeutic reasons is taught by an occupational therapist who is a full time member of the staff.

Religious instruction is given, for the most part, by volunteers, although in some of the homes such instruction is given by the foster mother.

School instruction is provided through home teachers who are assigned to each home through the local school department.

In a medical foster home placement there are two distinct goals: first to restore the child to a state of good general health, and secondly to

teach him through practice in the foster home ways of maintaining good health as well as teaching particular limitations which might be necessary for his particular condition.

The average length of care with a rheumatic infection is about eight months. In individual cases, however, it may be longer or shorter, depending upon the seriousness of the infection. A child may be adequately cared for in his home environment after the serious activity of the infection has subsided. In most cases a child is discharged when he is allowed nearly normal activities for eight hours each day. If the home cannot give adequate care when the child has such activities for eight hours each day, he may be transferred to a non-medical home where he may lead a more normal life in a natural family atmosphere.

Children in medical foster homes may be visited by two adults at regular visiting hours each week.

The homes in this category are situated within a five mile radius of Boston in order to be readily accessible to both the physician and social worker. In 1943 there were five medical foster homes in use, the largest accommodating fourteen bed cases, the smallest two. A total of forty bed cases could be cared for at one time.[2]

Non-medical foster homes are for children who may have nearly normal activities more than eight hours a day. Children in these homes lead a more normal home life. Most of them attend school and church in the local community and take part in the life of the foster family much as they would in their own family group.

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2 House of the Good Samaritan, The Arrow, 1:2, May, 1944.

Although the foster mother of a non-medical home does not need to have nursing training, it is necessary for her to have some understanding of the limitations necessary for the particular children in her care, as well as the importance of nourishing food and adequate rest essential for the maintenance of good health. Although the staff physician does not regularly visit children in non-medical foster homes, new homes in this category are submitted to him for approval.

Medical care of children in non-medical foster homes is given through local facilities or through a hospital clinic in Boston.

Visiting hours in these homes are arranged at the convenience of both the foster parents and the child's own parents. Although there are no particular rules regarding the number or ages of those who may visit, it is understood the child will be fully protected against any infectious disease.

Foster homes in this category are not restricted to the five mile radius of Boston. Accessibility for parents and social worker is emphasized rather than distance. These homes range in distance from five to one hundred miles from Boston.

Apart from foster homes, placement under the Children's Mission supervision may be arranged at the House of the Good Samaritan in Boston or with the group of rheumatic children at Sharon Sanitorium.

It is the policy of the Children's Mission not to place in foster homes children who are particularly ill and need constant medical supervision. Such a child, if accepted for placement, would be placed at the House of the Good Samaritan or at some other hospital if this were not available. Such cases are usually referred directly to the hospital, but in the event one is

accepted by the Children's Mission, payment of care in the hospital is usually shared jointly by this institution and the Children's Mission or completely by the latter if this is necessary.

In the year 1943, twenty-one children under the supervision of the Children's Mission were placed at Sharon Sanatorium.[3] This group of children with rheumatic infections are in a building apart from the other patients at the Sanatorium and receive both hospital and convalescent care in an institutional environment. This is an experiment in fresh air care of rheumatic patients. Payment for board of the children placed under its supervision with this group is made by the Children's Mission.

In all placements the general policy is to allow the parents to assume as much responsibility for board payments and provision of clothing as is possible for them in proportion to their income.

Supervision of the child in his own home following placement is seen as an increasingly important part of the program in the care of rheumatic children. Of the three hundred and eighty-five children cared for by the Children's Mission in 1943, eighty-six of these were actively supervised in their own homes. A great majority of these were children with rheumatic infections.[4]

Supervision may continue for three months or longer after a child has returned home. The length of this supervision depends upon many factors, the most important of which are the rapidity with which arrangements for clinic or other medical follow-up may be made, the ability of the child to

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3 Children's Mission to Children, op.cit., p. 3.

4 Ibid., p. 3.

readjust to his home environment, and the family's understanding of the child's condition and the care he needs.

In addition to the physician, dentist, laboratory technician, and occupational therapist, previously mentioned, the staff of the Children's Mission consists of a general secretary, a supervisor of case work, five case workers, and four office workers. It was this group, in addition to the other facilities mentioned in this Chapter, which made possible the care of three hundred and forty-five children in 1943.[5]

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5 Ibid., p. 3.

CHAPTER V

FOSTER HOMES USED FOR THE SUMMER GROUP PLACEMENTS OF 1938

Of the three foster homes used for the group placements in the summer 1938, two were the infirmaries of two private schools near Boston, while the third was a small private school in southern New Hampshire. The children in all three homes were supervised by the same social worker throughout placement. For the two groups near Boston recreational projects and occupational therapy were planned by the occupational therapist employed by the Children's Mission, while in the foster home in southern New Hampshire the foster father and mother planned these projects.

In the discussion of these groups, each has been named for the school which was used. Children were classified according to age, the older boys and girls being placed separately and the younger children under ten were placed together.

The Lincoln group occupied the entire three floors of the infirmary building of the Lincoln School which is situated in a suburban community of Boston. The spacious lawns and pine groves near this building provided ample play space.

The children slept in four large dormitories which were used as wards by the school during the school year. In addition to these, there were large rooms in the basement which were used as playrooms, as well as screened porches on either end of the building.

A definite daily program was planned by the foster mother. This program included play and rest hours and definite periods for occupational therapy. The children did much of the lighter housekeeping under supervision. This was particularly beneficial in the area of food preparation, as menu planning and food values could be considered in relation to general health.

Each week a special trip was planned for the entire group. These included visits to Wellesley College, the Sharon Bird Sanctuary, the Wayside Inn, and the Pioneer Village. These trips were planned to give the children experiences in addition to those of regular camp routine and in many cases provided an opportunity for "traveling" which many of the children had never had. In addition to these trips the publishing of a camp newspaper was undertaken. This, of all the groups, had the largest variety of activities.

All the children in this group were of the Catholic faith and a local priest visited the broup every two weeks.

The foster mother who cared for this group had two assistants as well as the part-time assistance of several interested people. This latter came in the area of providing transportation for trips, or special refreshments for parties. The foster mother had training as a nurse and had maintained a medical foster home before undertaking this summer project at the Lincoln School.

The camp program lasted for seven weeks and during this period fourteen children received care. Of the fourteen children, ten had rheumatic infections. These boys and girls ranged in age from eight to ten.

The second foster home used was the infirmary building of the Hathaway

School which is situated in a residential suburb of Boston. The campus of this school was very large and there were extensive areas of lawn and groves in which to play. In addition to the large space, there were swings and other playground equipment. Because of the limitation of activity for some of the children, this equipment was used only under supervision.

The first and second floors only of the infirmary building were used. Instead of dormitories, there were small rooms, each accommodating two children. Indoor play space was provided by a playroom and the large school gymnasium.

The daily program was similar to that of the Lincoln School with the exception of the special trips. The Hathaway group made up for this by having parties and other special recreational activities within the camp setting. The children in this group were Catholic and they were visited several times during the summer by a local priest.

The foster mother who cared for these children had no training as a nurse, but had practical nursing experience. She had maintained a non-medical foster home before undertaking this summer project. She also had two assistants as well as the part-time help of several interested people. This latter came in the area of providing drawing lessons and similar recreation. The summer program lasted for seven weeks.

Of the nineteen children in this group, eighteen had rheumatic infection. The ages of the children ranged from ten to nineteen and this was considered the group used for older girls.

The third foster home was the Butler School, a small private school in southern New Hampshire. The buildings consisted of a large central house in which were a dining room and a living room on the first floor, and several

bedrooms accommodating four boys in each room on the second floor. In addition to this large building, there were several smaller buildings which included a woodworking shop, a small barn, and tool sheds. Most of the boys slept in tents which were pitched near the main house; indoor sleeping quarters were provided for those who had more serious conditions. In the event of poor weather, there were adequate facilities for sleeping accommodations indoors.

Outdoor play space included two and one-half acres of land surrounding the school buildings, as well as nearby woods and fields. Indoor play space in addition to the various school buildings was also provided by a local gymnasium, the use of which was given to the school.

For this group there was no definite schedule of activities as for the other two groups. Various farm activities, a small amount of creative work, and unsupervised play comprised the recreational program. In addition to this, several weekend trips to the mountains and other places of interest were planned for those who were able to take part in such activities. Since these trips often involved hiking, some of the children were unable to go because their activities in this direction were limited.

The children in this group attended local churches while in placement.

This group was the only one having both a foster father and foster mother. During the winter months they maintained a small private school for boys in the intermediate grades. They had both had experience in working with children in private schools before starting a school of their own. Their only assistants were those who helped with the housekeeping, they themselves taking full care of the children.

This group project lasted for seven weeks. It was considered to be a group of older boys, although the age range was from eight to fourteen. The two eight-year-olds in this group were particularly mature boys who fitted in well with those several years older. Of the sixteen boys in this group, eleven had rheumatic infections.

Medical supervision of the children in the homes near Boston was provided by the physician on the staff of the Children's Mission. In addition to this, if a special medical problem developed, children were referred back to the hospital clinic which had requested placement for the child. The children in the Butler School in New Hampshire were supervised by a local physician. In addition to this, all children were examined at the time of placement and at the time of discharge to their own homes.

CHAPTER VI

CASE PRESENTATION

INTRODUCTION

As stated in the introductory Chapter, the purpose of this study is to present a picture of the summer group placements made by the Children's Mission to determine the benefit of such placements to the children. The author feels that no clear picture can be given without the inclusion in this study of actual case situations which show more clearly than generalizations exactly what was accomplished and how the placement of the child related to his needs.

Of the thirty-nine cases studied, twenty have been chosen for case presentation. Since the medical situations of the children were similar, selection of the cases to be studied was based upon the numbers in each group. Since these placements were primarily for children with rheumatic infections, those with other diagnoses were eliminated. The cases were chosen by selecting alternate names in a random listing of those in each group.

Each case story attempts to present the child's history of rheumatic infection, his condition at the time of placement, his camp experience, his physical and social adjustment following placement, and, in summary, gains made or changes brought about by placement.

Both the social and medical problems of the child are discussed in each

situation, since both these factors are considered in the records of the children at the Children's Mission.

The cases are presented according to the camp group to which they belonged, thus allowing the possibility of comparison of cases within the group as well as comparison among the groups.

The Butler Group

Case 1

Robert, aged ten, was the youngest of three children in a family of Irish descent. He was referred for summer placement by the New England Hospital for Women and Children with a diagnosis of quiescent Sydenham's Chorea and a good prognosis. He had a history of chorea from the age of four, having received hospital treatment at the House of the Good Samaritan in 1935, non-medical foster home care by the Children's Mission in 1936, and hospital treatment at Boston City Hospital in 1937. He was placed with the Butler group for seven weeks in the summer of 1938.

Robert progressed both physically and socially while in placement. He identified readily with the group and thus lost much of his seclusiveness and shyness. He made many friends and was well liked by the other children. This was especially important as he had been described as "asocial" by the Habit Clinic in the spring of 1938.

He gained five and one-half pounds while in placement. There was no definite return of chorea, although he had occasional periods of involuntary twitching. Because these seemed to have no connection with his activities, they were not considered to be of choreic origin.

Robert did not get along well with his mother at home and his improvement in placement indicated that his choreic condition, as well as his social attitude, were closely related to unstable conditions at home.

The hospital record shows that he remained well until the spring of 1939. He lived with his grandmother upon return from placement and throughout this period he remained well. Upon return home, however, the choreic form movements became more marked. At this time he was again referred to the Children's Mission for placement, but the case was not accepted because there were resources within his family for placement away from his mother.

When this placement was accomplished, his good health was maintained.

The placement of Robert was successful from both a medical and social point of view. His general health was improved to the point he was able to maintain this when in a stable environment for the greater part of the school year. His mother was unable to understand his condition nor the part she played in maintaining his health. Because often there were no apparent symptoms of his illness, she believed him to be entirely well, and even when periods of involuntary twitching occurred, she attached little importance to these. Robert learned a great deal about the care he required and was able to interpret this to the adults with whom he lived. Placement also acted in a diagnostic capacity to show that his choreic condition was closely related to his emotional instability.

Case 2

Richard, aged seven, was the youngest of five children in a family of Italian descent. He was referred for summer placement by the Massachusetts General Hospital with a diagnosis of rheumatic heart disease, and a guarded prognosis. He had a history of rheumatic fever from the age of four, receiving care at home from Boston Dispensary doctors in 1934. In 1935 he was placed with the Children's Mission in a non-medical foster home and returned to his home in 1936 where adequate care was given. He was placed with the Butler group for six weeks in the summer of 1938.

Richard progressed both socially and physically while in placement. He had been petted and given his own way at home, but in the group he behaved very well, fitted well into the routine, and showed marked improvement in accepting responsibility. He was easily controlled by the feelings of the group. Richard was well liked by the other children and enjoyed the group life a great deal. This was important because he was a year younger than any other child in the group. The acceptance he received from the foster parents and the group gave him much self confidence.

He gained six pounds while in placement. Except for a serious heart condition which remains unimproved, his general health upon return from placement was excellent.

He has been protected a great deal at home by his mother and was not allowed to have even the limited activity recommended by the doctor. The activities in which he participated while in placement showed the mother that he needed care but should not be treated as an invalid.

The hospital record shows that he was referred to the Children's Mission in December, 1938, for placement with the Rheumatic Fever Group at Sharon Sanatorium as a preventive measure. He was receiving good care at home and it was found that his heart damage was too great to enter this group. He remained well until December, 1940, when he was in the Massachusetts General Hospital with acute rheumatic fever. He was transferred to the House of the Good Samaritan and remained there a year for convalescent care. He has been well since that time.

Richard maintained the gains made in summer placement for two and one-half years. Because of heart damage, he was allowed only restricted activities, but the group experience had helped him to accept these and to find less active forms of entertainment. His mother became more aware of his real condition and his limitations, giving him more responsibility in caring for himself. The social worker helped her to understand more fully the physical care Richard needed in terms of rest and food. From this she became more aware of the importance of her attitude toward Richard's condition in maintaining his health.

Case 3

Philip, aged eight, was the second youngest of seven children in a family of Irish descent. He was referred for summer placement by the Boston City Hospital with a diagnosis of Rheumatic Heart Disease and a good prognosis. He had no known history of rheumatic infections. Philip was placed with the Butler group for seven weeks in the summer of 1938.

His progress was more marked physically than socially while in placement. He was very eager to go to camp, but was homesick for several days after arrival. He was a very small child and because of this the other children tended to leave him out of their activities. Because his activities were not restricted, however, he took part in everything as much as possible and felt himself a part of the group.

He had nocturnal enuresis, evidently having had this condition at home although it was denied by the mother. This improved a great deal by the establishment of regular toilet habits. He was very happy with the group and did not want to return home. He gained four pounds in weight and, since it was difficult for him to gain, this was considered to be a greater improvement than the actual gain would indicate.

Little interpretation was done with the mother. She had little understanding of his condition and, although she appreciated the obvious physical signs of his improvement upon return from placement, she had no real understanding of how this gain could be maintained. In spite of this he remained well consistently after his return home. There was no hospital record of him, but the family was followed by the Catholic Charitable Bureau.

The placement of Philip may be called successful in that he maintained the gains consistently throughout the years following placement. Since he was not restricted in activities, it appears that his condition was not very serious; thus the placement was a preventive rather than a curative form of treatment. Neither the child nor his mother gained a better understanding of his care through the placement.

Case 4

Donald, aged ten, was the second oldest of five children in a family of Irish descent. He was referred by the Boston City Hospital with a diagnosis of quiescent chorea and a good prognosis. He had a history of chorea from the age of seven when he was placed in a non-medical home by the Children's Mission for four months. At the time of discharge he had no symptoms of chorea. He was placed with the Butler group for seven weeks in the summer of 1938.

Donald progressed both physically and socially while in placement. He liked camp very much and got along well with the other children. He was very negligent of personal cleanliness and because of this he was not as popular as he might have been. He responded well to group discipline and through this was able to accept and understand any restrictions imposed.

He gained four pounds while in placement and, although he caught both poison ivy and impetigo, these were healed by the time he returned home.

No follow-up visit was made after he returned home.

The hospital record shows that he returned to the clinic and was found to be much improved. No evidence of heart pathology or chorea were found and he was discharged from the clinic in 1941 with a diagnosis of no disease.

The placement of Donald may be said to have been successful both socially and physically. Because there was no follow-up visit and the hospital contacts were brief, it is difficult to determine exactly how much placement contributed to his permanently improved condition. From all information obtainable it would appear that he learned a great deal while in placement and could continue the application of this at home. He appeared to have no deep emotional problems, but adjusted normally and thoroughly enjoyed his camp experience.

Case 5

Christopher, aged 10, was the youngest child and only boy of four children in a family of Italian descent. He was referred for summer placement by the Boston City Hospital with a diagnosis of rheumatic heart disease and a good prognosis. He had a history of rheumatic infection since the age of nine. He was followed by the Cardiac Clinic at Boston City Hospital and received adequate care at home. He was referred to the Children's Mission for summer placement in 1937 but there were no vacancies. He was placed with the Butler group for seven weeks in the summer of 1938.

Christopher's greatest gain from placement was increased understanding of his condition and the care he should have. While in camp he was well liked by other boys and was greatly helped by group discipline. He responded very quickly to suggestion but not to direct commands. He resented the fact that his activities were restricted and did not like to be reminded of this. It was in this area particularly that the group discipline was successful. He gained in self reliance and in accepting responsibility.

He gained three pounds while in placement and was in good health upon return home. Because of his previous condition of malnutrition it seemed to be difficult for him to gain in weight.

Since he was the youngest and only boy he was greatly spoiled at home. His mother was anxious that he follow the doctor's instructions, but her lack of knowledge in caring for the child, as well as her difficulty in understanding English, made this difficult. Christopher helped her a great deal in understanding the care he

needed, for in spite of his resentment concerning the restriction of his activities he learned a great deal from this. Upon his return home he maintained very closely the schedule followed while in camp in regard to food and rest.

The hospital record shows that following placement he made slow but steady progress and has not had a recurrence of rheumatic infection.

The placement of Christopher was successful from both a medical and social point of view. His improvement in general health, combined with his increased understanding and acceptance of his condition, have protected him from further illness of a rheumatic nature. His mother, also, was helped, by the placement and interviews with the social worker, to realize better the kind of discipline that was most successful with Christopher. She was very sincere in her desire to learn about Christopher's condition. She requested placement for the summer of 1939, but this was impossible because the Children's Mission did not make summer placements that year. He was not ill at this time, but his mother desired this placement as a preventive measure.

Case 6

George, aged 10, was the third oldest of seven children in a family of Italian descent. He was referred for summer placement by the Massachusetts General Hospital with a diagnosis of potential heart disease and a good prognosis. He had a history of rheumatic fever from the age of nine. He received treatment in the Massachusetts General Hospital and was later placed in a medical foster home by the Children's Mission for two months. Two months later he had a slight rheumatic flare-up, but was given adequate care at home and made a good recovery. He was placed with the Butler group for seven weeks in the summer of 1938.

George gained both socially and physically while in placement. From a very quiet, accepting child, he became more active, talked easily and expressed his feelings readily. He was well accepted by the other children and enjoyed being with them.

He gained five pounds while in placement, but there was no evidence on his part of increased understanding of his condition.

His mother was very protective of him, often restricting his activities even beyond the doctor's recommendations. George's experience of camp gave her a real understanding of the amount of activity he could have and helped her to realize that he could take some responsibility in this direction himself. He accepted this responsibility readily and managed very well.

The hospital record shows that he remained well until February, 1939, when he had a serious flare-up of rheumatic fever. He was given adequate care at home and returned to school the following September.

Placement of George was successful from both a physical and social point of view. The social poise he gained while in placement helped him a great deal, especially in association with his brothers and sisters. He later joined the Boy Scouts and attended classes in a settlement house, gaining not only socially but receiving directed recreation as well. His physical gain lasted for six months following placement. Following the flare-up in February of 1939, he has made continued gains, reporting regularly to the Cardiac Clinic at the hospital.

Through placement George learned to accept the responsibility of restricting his activities when necessary. His mother realized more fully the implications of George's illness and she began to treat him as a normal child with minor restrictions rather than as an invalid.

The Hathaway Group

Case 7

Elizabeth, aged eleven, was the third oldest of six children in a family of Irish descent. She was referred for summer placement by the New England Hospital for Women and Children with a diagnosis of quiescent rheumatic heart disease and a good prognosis. She had a history of rheumatic infection from the age of ten when she was a patient in the hospital with rheumatic fever, later being placed for one month in Wellesley Convalescent Home. Since then she had been followed by the Heart Clinic at the New England Hospital. She was placed with the Hathaway group for seven weeks in the summer of 1938.

Elizabeth progressed a great deal both physically and socially while in placement. She appeared to be very shy and repressed but gained much in self reliance and poise while in placement. She was sensitive and insecure, but lost much of this in knowing that she was accepted both by the foster mother and the other children. She especially enjoyed the trips planned by the foster mother to places of historic interest. These gave her a feeling of maturity which she had not previously experienced.

She gained nine and three-quarters pounds while in placement and learned much about her condition. She was one of the few children who was over-careful about participation in activities; being with other children helped her to realize that she could do many things she had not supposed possible. Her mother visited her each week and was both appreciative and understanding of suggestions from the foster mother for Elizabeth's care at home. Through interviews with the social worker, she also came to feel more secure and more understanding in her care of Elizabeth.

The hospital record shows continued good health following the placement. Some of the poise gained in placement was lost in an emotional upset due to a change in school routine, but was restored after a short period of receiving instruction from a visiting teacher.

The placement of Elizabeth was very successful from both a physical and social point of view. Her general health improvement has been maintained since placement. This is due in a great measure, in the opinion of the hospital, to both the mother's and child's understanding of the latter's condition. Elizabeth changed from a child who thought of herself as an invalid to one who could enjoy life normally with only a few necessary restrictions.

Case 8

Verna, aged eleven, was the oldest of five children in a family of Italian descent. She was referred by the Boston City Hospital with a diagnosis of rheumatic heart disease and a fair prognosis. She had no known history of previous rheumatic infection. She was placed for seven weeks with the Hathaway group in the summer of 1938.

Verna progressed exceptionally well both physically and socially during placement. She had had little if any social experiences outside her own home, and the visits planned by the foster mother to nearby points of historic interest meant a great deal to her. She was also much interested in caring for her own possessions and this

gradually expanded into a real interest in doing things around the camp. She was very well liked by the other children because of her sincerity and desire to be helpful.

She gained over fifteen pounds while in placement and learned a great deal about maintaining her general health as well as making certain exceptions for her own condition. She was especially interested in all health rules and in menu making. One of her younger brothers had a rheumatic condition and she was able to use much of her knowledge effectively in helping both him and his family accept his condition and give him the best care possible.

The hospital record shows a consistent gain in weight and maintenance of general good health since placement.

The placement of Verna appears to be the most successful of any of the group placements. She not only made an exceptional gain physically, but also learned a great deal about the maintenance of health and the general care of a condition such as hers. Her parents were unable to understand these two factors previously, but her interest in them after placement helped the parents to understand them more fully. She has maintained good health since placement.

Case 9

Viola, aged ten, was the second youngest of eight children in a family of Irish descent. She was referred for summer placement by the Massachusetts General Hospital with a diagnosis of rheumatic heart disease and a good prognosis. She had no known medical record of previous rheumatic infections. She was placed with the Hathaway group for seven weeks in the summer of 1938.

Viola progressed physically while in placement, but made little progress socially. Because of her illness she had been overindulged at home; this made acceptance of group life rather difficult for her. Not until very near the end of placement did she accept the routine or assume the responsibility expected of her. She was well liked by the other children because of her adult sense of social ease and tact.

She gained four pounds while in placement and her heart condition appeared to be improved. Neither Viola nor her parents gained any real understanding of her condition or the care she needed. They visited often while she was placed, interrupting the camp program at odd hours and showing little regard for attempts made by the

social worker or the foster mother to cooperate in giving her the correct care.

From the hospital records and follow-up visit it appears that Viola was able to maintain relatively good health throughout the school year following placement, but since then has had various flare-ups of the rheumatic condition as well as various other illnesses.

The placement of Viola appears to have been only temporarily successful from a physical point of view. Because of much over-indulgence by her parents, she would not accept responsibilities or take part in the camp program in a normal way, requiring, rather, individual attention.

Although efforts were made both on the part of the social worker and the foster mother, no change in the parents' attitude of over-indulgence and lack of understanding was noted. It was felt that Viola should not have been placed by Children's Mission since the parents could have undertaken at home care which would have resulted in such minor success as that from placement. Viola has been in moderately good health, interrupted by occasional rheumatic flare-ups.

Case 10

Esther, aged nineteen, was the youngest of six children in a family of Irish descent. She was referred for summer placement by the Peter Bent Brigham Hospital with a diagnosis of rheumatic heart disease and a good prognosis. She had a history of rheumatic infection since the age of thirteen when she was referred to the Cardiac Clinic at Children's Hospital. She never became seriously ill, but was followed consistently by various clinics. She was placed by the Children's Mission in a non-medical foster home for two months in 1937. Esther was placed with the Hathaway group for seven weeks during the summer of 1938.

She was placed both for physical care and help in maturing socially. This latter was not particularly successful. For the first two weeks she acted as an assistant to the foster mother, but later associated as an equal with girls of eleven or twelve with whom she formed a clique. Although her intelligence appeared to be normal for her age, her social poise was not increased by her camp experience. Her behavior in this camp situation was not un-

social worker on the foster mother to cooperate in giving her the correct care.

From the hospital records and follow-up visit it appears that Viola was able to maintain relatively good health throughout the school year following placement, but since then has various flare-ups of the rheumatic condition as well as various other illnesses.

The placement of Viola appears to have been only temporarily successful from a physical point of view. Because of such over-indulgence by her parents, she would not accept responsibilities or take part in the camp program in a normal way, requiring, rather, individual attention.

Although efforts were made both on the part of the social worker and the foster mother, no change in the parents' attitude of over-indulgence and lack of understanding was noted. It was felt that Viola should not have been placed by Children's Bureau since the parents could have overtaxed at home care which would have resulted in much sicker condition as that from placement. Viola has been in moderately good health, interrupted by occasional rheumatic flare-ups.

Case 10

Esther, aged nineteen, was the youngest of six children in a family of Irish descent. She was referred for summer placement by the Esther Dean Bridges Hospital with a diagnosis of rheumatic heart disease and a good prognosis. She had a history of rheumatic infection since the age of thirteen when she was referred to the Cardiac Clinic at Children's Hospital. She never became seriously ill, but was followed consistently by various clinics. She was placed by the Children's Bureau in a pre-natal foster home for two months in 1937. Esther was placed with the Rockaway group for seven weeks during the summer of 1939.

She was placed both for physical care and help in meeting socially. This latter was not particularly successful. For the first two weeks she acted as an assistant to the foster mother, but later associated on an equal with girls of eleven or twelve with whom she formed a clique. Although her intelligence appeared to be normal for her age, her social poise was not increased by her camp experience. Her behavior in this camp situation was not un-

usual as previous placement by the Children's Mission was felt to be unsuccessful in helping her to gain social maturity.

She progressed rather well physically, gaining nine pounds. She had occasional shortness of breath and heart pains but these symptoms occurred following periods of over-exertion.

The hospital records and follow-up visit indicated that in spite of her apparent lack of interest in the camp program she learned a great deal about caring for herself. However, her social immaturity and lack of responsibility often prevented her from carrying out recommendations which she knew to be of benefit to her. Since placement in 1938 she has been continuously well, although her heart condition has not changed markedly.

The placement of Esther was successful from the physical point of view and, in a less marked way, from a social point of view. Her physical gains have been maintained and she has been allowed to work normally. It is questionable whether socially such a group placement with girls younger than herself was the best plan which could have been worked out for her. Although her knowledge of health and maintaining this did not appear great while in placement, she apparently absorbed much of what was taught. This was particularly important in her case, since her family was able to understand little of the kind of care she needed and this responsibility was entirely her own.

Case 11

Edith, aged fourteen, was the oldest of two children in a family of Italian descent. She was referred for summer placement by the Massachusetts General Hospital with a diagnosis of rheumatic heart disease and a guarded prognosis. She had a history of rheumatic infection from the age of two. She had three attacks of chorea, receiving treatment for the third attack at the House of the Good Samaritan for five months at the age of seven. At the age of thirteen she received hospital treatment for rheumatic fever for a period of three weeks. She was placed with the Hathaway group for seven weeks in the summer of 1938.

Edith progressed both physically and socially while in placement. She became involved in the clique formed by the oldest girl in the group, but she was not too easily influenced by this selected group.

She was especially interested in learning new things, and menu making and cooking interested her particularly. Her mother had died the year before the placement and the home had been disrupted because of this. The routine at the camp, although difficult at first, helped Edith a great deal as training in planning activities. Since she took the mother's place in the family, the responsibility for her care rested solely upon her. She learned a great deal about this in placement and eagerly looked forward to applying it on her return home. She gained twelve pounds while in placement and had no heart symptoms.

The hospital records and follow-up visits indicated that she got along very well at home with the exception of an appendectomy in December, 1939. She recovered from this normally and has shown no rheumatic symptoms. She was married in June, 1942, and has one child.

The placement of Edith was very successful from both a physical and social point of view. The physical gains made have been maintained to the present. She attended clinic regularly after return home from placement and her contacts there showed that she was carrying out many of the things she had learned while in placement.

Case 12

Charlotte, aged eleven, was the youngest of three children in a family of Italian descent. She was referred for summer placement by the Massachusetts General Hospital with a diagnosis of potential rheumatic heart disease and an excellent prognosis. She had a history of rheumatic fever from the age of ten when she had an attack of rheumatic fever. She was cared for adequately at home by her mother, but was placed in a medical foster home by the Children's Mission for a short period because of the mother's illness. She was placed with the Hathaway group for three weeks in the summer of 1938.

Charlotte showed slight physical but no social progress while in placement. In three weeks of placement she did not become at all adjusted to the group, screaming to be taken home whenever the social worker visited. The mother wished that she remain in placement, but found it difficult to insist upon this when the child appeared to be so unhappy.

She was very much overweight and it was hoped that she would lose weight while in placement. She lost only one pound in three weeks, however. She appeared to learn nothing of the care needed for her condition, but talked and thought constantly of returning home.

No follow-up visit was made, but the hospital reports indicate that she had a severe flare-up six months after placement but recovered from this and since then has been well.

The placement of Charlotte does not appear to have been successful from either a physical or social point of view. The hospital definitely connected her illness in the winter with the fact that she had received inadequate care following her return home from the summer placement. She appears to have had little concept of the care needed for her condition until after this illness.

Case 13

Joanna, aged fourteen, was the fourth oldest of eight children in a family of Irish descent. She was referred for summer placement by the Peter Bent Brigham Hospital with a diagnosis of active rheumatic heart disease and a fair prognosis. She had a history of rheumatic infection from the age of twelve when she had an attack of chorea accompanied by rheumatic heart disease. She had another recurrence at the age of thirteen, and was placed by the Children's Mission in a medical foster home for a two months period. She was placed with the Hathaway group for seven weeks during the summer of 1938.

Joanna progressed more physically than socially during placement. She was at first a friendly, energetic girl who participated in all activities with the greatest enjoyment. She, too, however, became involved with the clique which developed among the older girls. In this way she was drawn in two directions--to be with the larger group and participate in its activities and to be with the clique and enjoy the distinctions of being with older girls. It appeared that she was very easily influenced by those around her, as she tended always to join the strongest group.

She progressed well physically, gaining seven pounds while in placement. She learned a great deal about foods and their relation to health, as well as about housekeeping in general. Her mother, who was very protective of Joanna at home, objected to her performance of various light household tasks with the other children. The doctor from the Clinic which referred Joanna for placement was consulted in this matter and he strongly advised such supervised activity. Through this the mother came to understand more fully that Joanna did not need to be treated as an invalid, and she became much more willing to let her daughter assume the responsibility of limiting her own activity.

At the time of her return home, the mother was interviewed by the social worker and plans were discussed for the continuance of the care given in the summer throughout the winter at home. The mother remained somewhat over-solicitous, but her understanding of Joanna's condition had increased a great deal. The hospital record shows that she remained well until December, 1940. In the period from 1938 until 1940 the mother engaged a visiting teacher on her own initiative, although the Clinic had recommended that Joanna return to school. Following the flare-up in December, 1940, the mother proved to be both over-solicitous and uncooperative. Joanna did not want to return to school and was fast becoming a cardiac invalid.

The placement of Joanna was successful from a physical point of view. She maintained for two and one-half years the gains made during placement. Socially she regressed from an outgoing happy child to a moody withdrawn one. Neither she nor her parents attained a better understanding of the care she required. Although her mother's attitude improved for a short time, it appeared that neither Joanna nor her mother wished to feel any different toward the former's illness.

Case 14

Berenice, aged twelve, was the oldest of four children in a family of Irish descent. She was referred for summer placement by the Boston City Hospital with a diagnosis of rheumatic heart disease and a good prognosis. She had a history of rheumatic infection from the age of eleven when she was placed for a five month period in a non-medical foster home by the Children's Mission. Her diagnosis at that time was quiescent rheumatic heart disease and malnutrition. She was placed with the Hathaway group for seven weeks in the summer of 1938.

She progressed both socially and physically during placement. She had known the foster mother previously when placed before by the Children's Mission and tended to identify herself very closely with the foster mother. Later, however, she accepted her place in the group, becoming more independent and self-reliant.

She gained eight pounds while in placement and, although not well for several days during the early part of placement, this did not seem to affect her general health. This illness seemed to be due to damp weather and was not a recurrence of rheumatic symptoms.

It was particularly important that Berenice learn how to maintain

her general health and care for her particular condition because her mother appeared critical of any limitations which Berenice had. The mother indulged in much self-pity and was over-concerned about herself to the extent that it was felt she was psychoneurotic. There was much antagonism between Berenice and her mother because of the latter's attitude. The security which she gained while in placement helped her to accept her mother and to accept the responsibility of her own care.

No follow-up visit was made, but the hospital records show that her general health has remained good but that her heart condition has remained the same.

The placement of Berenice appears to have been successful both physically and socially. She has consistently maintained good health since placement. An increased understanding of the care needed and acceptance of the responsibility of caring for herself seem to be the most important things gained from placement. She was able to get along better with her mother because she felt more secure in herself and removed the responsibility of her care from her mother. At the time of placement she was very immature, especially in her play interests, but while in placement she grew to accept the standards of other twelve year olds.

Case 15

Alice, aged eleven, was the next to the youngest of five children in a family of Irish descent. She was referred for summer placement by the Massachusetts General Hospital with a diagnosis of cured chorea and a good prognosis. There is no definite record of the history of her choreic condition. She was placed with the Hathaway group for one week in the summer of 1938.

Alice progressed neither physically nor socially in placement. In her happier moments in placement she was cooperative and seemed to enjoy herself. She was very homesick, however, and constantly wanted to return home. She was discharged without a medical check-up as her father took her home the first visiting day.

She gained no weight while in placement, and neither she nor her parents appeared to obtain any increased understanding of her condition. No follow-up visit was made, but the hospital record shows that she remained well throughout the summer and the following years since placement except for slight colds and losses in weight.

The placement of Alice was not considered successful as no gains were shown. It appears that placement was not necessary in this particular case since the family seemed well able to give adequate care at home. Alice had been protected a great deal at home, and transferring her into a strange group when her status was not ready-made for her proved to be very frightening to her. Little explanation of placement or discussion of it with Alice seems to have been done; this would appear to be one reason for her inability to adjust. Alice has been in moderately good health since placement.

The Lincoln Group

Case 16

Linda, aged ten, was the third youngest of seven children in a family of Irish descent. She was referred for summer placement by the Boston Dispensary with a diagnosis of rheumatic heart disease and a good prognosis. She had a history of rheumatic infection from the age of eight when she had an attack of chorea, later developing rheumatic heart disease. She received good convalescent care at home. She was placed with the Lincoln group for two weeks in the summer of 1938.

Linda was not able to join the Lincoln group until the last two weeks of the summer as there was not room enough for her until another child had left. She progressed both socially and physically in these two weeks. She gained two and one-half pounds and her heart condition was found to be slightly improved following placement.

Although she entered the group very late, she adjusted easily and enjoyed the whole experience very much. She became a part of the group at once and was very well liked by the other children. The hand work classes interested her a great deal and she showed much originality in the things which she made. She was intensely interested in every activity, apparently making up for the time she had missed. She learned a great deal about caring for herself and came to accept restrictions more easily. Her parents appeared to have a good understanding of her condition, but had previously been unable to put any of the responsibility for her own care upon Linda.

The hospital records show that she remained well until May, 1939,

when she had a recurrence of chorea. At this time she remained in bed a month and since then had maintained a good standard of health. In 1942 the hospital again applied for summer placement of Linda. Her diagnosis remained the same, and it was believed she had a permanently damaged heart. She learned many new things, such as gardening, nature study and knitting while in this later placement. She also made a good gain in weight.

The placement of Linda was primarily for a vacation, as it was believed that the two week period was too short a time to accomplish very much socially or physically. She made good progress in both these areas, however. If she could have been placed for a longer period of time, her gain would doubtless have been in proportion. She maintained the physical gains for eight months following placement.

Case 17

Doris, aged seven, was the fourth youngest of eight children in a family of Italian descent. She was referred for summer placement by the Boston Dispensary with a diagnosis of rheumatic heart disease and a good prognosis. She had a history of rheumatic endocarditis and later developed rheumatic heart disease. She received adequate convalescent care at home. Doris was placed with the Lincoln group for seven weeks during the summer of 1938.

Doris progressed both physically and socially while in placement. She was not well liked by the others in the group at first because she appeared to be very insecure, sensitive and reticent. As she gradually found her place in the group, she gained much in poise and became interested in all activities. She had apparently been spoiled at home, as she constantly tried to make others do things her way. Being with a group helped her to realize the value of patience and unselfishness.

She gained seven pounds while in placement. Habit training as well as limitation of liquids were used in an attempt to control nocturnal enuresis which occurred about twice each week. No improvement was seen in this, however. It seemed to be closely connected with her nervous behavior rather than of organic origin.

The follow-up visit and hospital records show that Doris remained well until July, 1942. She received good care at home in the period 1938-1942, both she and her parents seeming to have gained much understanding at her condition through the former's placement experience. In August, 1942, she was placed in a medical foster home by the Children's Mission. She remained in this place for

over three and one-half months, during this time making very good progress. In 1943 she was placed for the summer in a summer foster home and made good progress there also.

The placement of Doris was successful from both a physical and social point of view. She maintained for four years the gains made in placement. Her parents became less indulgent and began to realize, from her camp experience, that despite a rather severe heart condition she could do many things with other children. Since the summer of 1943, she has maintained good health.

Case 18

Benedict, aged seven, was the youngest of three children in a family of Belgian descent. He was referred for summer placement by the New England Hospital for Women and Children with a diagnosis of quiescent rheumatic heart disease and a good prognosis. He had a history of rheumatic heart disease since the age of four when he was placed for two weeks in the summer of 1935 by the Children's Mission. He was placed with the Lincoln group for eight weeks in the summer of 1938.

Benedict progressed a great deal both physically and socially during placement. He gained eight pounds during placement and his general appearance was improved noticeably.

Being with a group helped him to become self-sufficient and not to depend upon his brother who was placed with the same group. The mother had constantly emphasized how much the boys depended upon each other and seemed to feel that this was admirable in both boys. In reality, the older brother felt a great responsibility for the younger one, while the latter resented the fact that he could not be with boys his age but must play with his older brother's friends. This group placement allowed each to follow his individual interests as well as to make friends and enjoy activities in keeping with his age. In this process Benedict lost much of his timidity and became independent. At first he craved much attention and cried if he did not receive this, but his new-found independence from his brother and his security in knowing his place in the group soon compensated for this craving for affection.

No follow-up visit was made, but the social worker had an interview with the mother at the time when the boys returned home from placement. The mother was helped a great deal in her understanding of Benedict's needs, but remained unimpressed by his new independence and out-going attitude. The hospital record shows that

he has remained well since placement, has consistently gained weight, and that his heart condition has improved.

The placement of Benedict was successful, from both a physical and social point of view, particularly in the latter area. The group discipline helped him to realize the meaning and acceptance of restrictions. Although the mother was not able to realize the value of his new independence, he was able to maintain this, developing a real personality apart from his brother's influence. Benedict has remained well since placement.

Case 19

Mildred, aged seven, was the youngest of four children in a family of Spanish descent. She was referred for summer placement by the New England Hospital for Women and Children with a diagnosis of subacute rheumatic fever and a fair prognosis. She had a history of rheumatic infection from the age of five when she twice received treatment at the House of the Good Samaritan for rheumatic heart disease and again at the age of six received hospital treatment for low grade rheumatic fever and rheumatic heart disease. She was placed with the Lincoln group for eight weeks in the summer of 1938.

She progressed both socially and physically while in placement, making the most progress in the latter area. She had been overindulged by her family and expected a great deal of attention. When she did not receive this, she became discouraged. She was also very sensitive. In the group, however, she soon came to realize that each person had certain responsibilities. She accepted this quickly and took part in activities easily. She had to be closely supervised while at play, as she did not seem able to accept the fact that her activities were limited, although other children of her age in the group realized this. There appeared to be a definite connection between her nervous, high-strung activity and her physical condition.

She gained six pounds during placement and learned to eat many nourishing foods which she previously refused.

Neither she nor her parents gained much understanding of her condition through placement. Her parents worked and were unable to visit the camp, also the social worker was unable to arrange an interview with them.

The hospital records show that she has remained consistently well

since placement, although she continued to have a serious food caprice. Her parents continued to be extremely over-indulgent and the hospital felt that she had been able to use her illness to obtain what she wished from her family. In 1942 she was again referred for summer placement. She remained in a summer foster home less than two weeks, however, being taken home by her father without the permission of the Children's Mission. In this placement she showed more completely the hospital's statement that she had not only been badly spoiled but that this had resulted in psychological damage to her.

The placement of Mildred was successful from the point of view of temporary physical gain and giving pleasure to the child. Neither she nor her parents gained any understanding of her condition through placement. She has maintained gains made in summer placement until the present. The placement in 1942 was preventive rather than a curative measure.

Case 20

Charles, aged ten, was the youngest of four children in a family of Irish descent. He was referred for summer placement by the Robert Breck Brigham Hospital with a diagnosis of rheumatic heart disease and a good prognosis. He had a history of rheumatic infection since the age of nine, when he received treatment for rheumatic heart disease for a period of eight months in the House of the Good Samaritan. Placement in a foster home was recommended at that time, but the parents objected a great deal. He was placed with the Lincoln group for eight weeks in the summer of 1938.

Charles progressed both socially and physically while in placement. Although he had expressed much interest in going away for the summer, he was very apprehensive and extremely nervous the first week. After that he improved each day, participating in group activity more readily, and was very happy. The new experiences in visiting new places and doing new things meant a great deal to him. He related very closely to a young man leader and this proved to have a very constructive influence upon him. Throughout this he gained self-reliance and self-confidence, but was inclined to emphasize this by using his fists rather frequently. He showed none of this independence with his parents, but became withdrawn and repressed with them.

He gained ten pounds while in placement and became better able to control his nervousness and excitement. His mother, through placement, gained much understanding about the care which Charles needed and was interested in learning everything possible about it. His

father did not cooperate in this, however. Because his condition, although much improved, was still serious following the summer placement, it was advised that he be placed in another foster home for the winter. The father objected to this strongly. Hospital record shows that Charles remained well until February, 1939, when he was admitted to the hospital with rheumatic heart disease, acute rheumatic fever, and questionable bronchial pneumonia. He remained in the hospital for over two months and made a good recovery. He had another flare-up of rheumatic fever in October, 1942, but has remained well since then.

The placement of Charles appears to have been successful from both a social and physical point of view, although only temporarily in the latter case. Both he and his mother gained more understanding of the kind of care he needed, but often were unable to carry this out because of the lack of cooperation on the part of the father. His physical gains made during placement were maintained for five months until the flare-up in February. This flare-up was to be expected because of his serious condition, even after the improvement from the summer placement.

CHAPTER VII

SUMMARY AND CONCLUSIONS

The three most common types of rheumatic infection are rheumatic fever, rheumatic heart disease, and chorea. Of these, rheumatic fever is the primary manifestation, often appearing in a mild form before symptoms of the other two types appear. It is important to consider preventive and curative measures in dealing with rheumatic infection because of its power as a crippling and killing agent. It causes the most deaths of any disease among children seven to ten years of age. When it is realized that the younger the patient the more danger of heart injury, the importance of good convalescent care is seen.

The Children's Mission, first in cooperation with the Massachusetts General Hospital and later with other hospitals throughout the City, has become an agency specializing in the care of convalescent children. There has been a gradual increase in the number of children with rheumatic infections referred for convalescent care until at present over seventy-five per cent of those in care are suffering from this type of disease.

With the gradual increase of cases of this nature, specialization in foster home placement has increased. The distinction between the "medical" foster homes and the "non-medical" foster homes and their uses has been shown. These were presented to show the differences between the usual type of placement of rheumatic children done by the Children's Mission as compared to the experimental summer group placements. Non-medical foster homes

are often used for summer placement, but this simulates the child's own family relationships. The summer group placement differs from this. It rather simulates a summer camp environment where children may learn through group experience.

The great majority of children placed in groups for the summer of 1938 were eleven years of age or older. As they entered upon adolescence, they were becoming acutely aware of the interests, opinions and attitudes of their contemporaries in contrast to their earlier dependence upon their family groups. Group placement would then appear to be the natural environment in which to teach good health habits and clearer recognition and responsibility on the part of each child for his own care.

The group of thirty-nine children chosen for this study were the majority of those placed by the Children's Mission in the summer of 1938. Since all thirty-nine had one or another type of rheumatic infection, it may be said that the group programs were planned around their needs.

Of the thirty-nine children with rheumatic infection, seventeen were boys and twenty-two were girls. With one exception, their ages ranged from seven to fifteen years. The exception was an immature nineteen year old girl who was placed primarily for help in gaining social maturity and secondarily to improve the general level of her health.

A comparison of the diagnoses of the children studied is of interest because it confirms several of the findings of authorities quoted in the Chapter on rheumatic infection. Five had diagnoses of quiescent chorea, three inactive rheumatic fever, and thirty rheumatic heart disease. In almost every case of a child with rheumatic heart disease or chorea, the previous history of rheumatic infection shows at least one attack of rheumatic

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fever. Since in every case the original infection had appeared one to three years previous to the summer placement, this again correlated with Dr. Philip Jeans, who stated that rheumatic infection reaches its peak among children seven to ten years of age.[1]

The hospitals which referred children for placement were the Boston City Hospital, Massachusetts General Hospital, Children's Hospital, Boston Dispensary, Peter Bent Brigham Hospital, Robert Breck Brigham Hospital, and New England Hospital for Women and Children. Over half the referrals came from the Boston City Hospital Pediatric Clinic or Rheumatic Fever Clinic and the Massachusetts General Hospital Cardiac Clinic.

The greatest number of children in the group were of Irish or Italian origin, correlating definitely with the proportion of racial groups in Boston. All of the children were of the Catholic faith.

Several conclusions which throw light on the value of group placements of rheumatic children may be drawn from the cases studied. In all but one case, definite physical gains were made while in placement. In this one case the child was removed from the group by the parents after such a short period that no definite gain could be determined. In only nine out of thirty-nine cases did the child in less than a year following placement have a rheumatic recurrence, and even in this group of nine the shortest duration of gain was six months. Of the thirty remaining cases, one child died in 1940 due to extreme neglect at home, and the twenty-nine others have remained well two years or longer following placement. Of these twenty-nine, twenty maintained the gains of placement through April of 1944.

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1 Jeans, op.cit., p. 455.

It is impossible to say that these gains were primarily the result of the form of placement, as group placement in contrast to foster home care. It may be said, however, that more competent and uniform medical supervision and activity direction was possible in the instance of group placements. In addition, the social worker was able to visit each group regularly in order to help both the foster mother and the children with any problem which might arise. The child, as he appeared in the group, was in a much more natural setting for observation than in the more formal interview usually possible in a foster home where the worker talks with the foster mother and later the child.

In almost every case, the more knowledge a child gained while in placement concerning his needs and special limitations, the less his susceptibility to recurrence. In addition, the more knowledge his parents gained, the better able they were to help him. This is particularly shown in Case 2, in which the child's mother came to realize that her over-protection was not the understanding care which he needed.

Case 1, although not as successful as Case 2, in that the gains made were not of as long duration, shows the responsibility assumed by the child in educating adults in regard to his care when this same contact proved to be impossible for the social worker.

Living with a group of children with similar conditions helped many of the children to realize that, while limitation of activities is not the normal thing, at least it was easier to accept such limitations from group pressure rather than at the suggestion of adults. For many of the children this was an entirely new experience and one which was of far greater importance to them than countless warnings by adults.

Evaluation of the group environment in relation to social development is more obvious than in the area of physical gain. For many of the children this group experience was the first they had had away from their home environment. It helped them to mature socially, particularly in the area of accepting responsibility. This ability to accept responsibility was important in their acceptance of their own physical conditions.

Group placement brought out another factor which, although not particularly emphasized in the cases present, is of particular importance to several of them. This is the emotional factor in relation to illness. This is shown especially in cases 1 and 13. In Case 1 the child's unstable emotional relationship with his mother accentuated his choreic condition. In Case 13, the child progressed physically in placement while her social relationships were satisfying to her but not particularly healthy. At home, however, although she received relatively good care, her mother's over-protective attitude accentuated the symptoms of her illness, and she became under this influence a cardiac invalid. There appears to be no physical basis for this chronic nature of her illness.

In recognizing the relation of the child's well-being to his own and his parents' understanding of his condition, it is the responsibility of the social worker to help them grow in knowledge and understanding of his illness. It is often assumed that the child, as well as his parents, learn this from the foster home placement. This is not entirely true, however, as both the child and the parents frequently accept with security the child's care in the foster home, but face with much fear and feeling of inadequacy the prospect of caring for the child at home. In the group studied the social worker's contact with the family had a definitely beneficial

effect upon the child's later health.

A summary of the conclusions would indicate that physical gains from group placement are marked, but that these cannot be attributed to group placement as contrasted with foster home care. In group placement more uniform and complete medical supervision, as well as better organized and directed recreational activities may be provided. The social development of the children is more easily traceable to the form of placement in that the social maturity gained by group contacts is demonstrated in every-day behavior. A definite relationship is seen between social maturity and acceptance of the responsibility of his needs and limitations on the part of the child.

Approved,

Richard K. Conant

Richard K. Conant, Dean

SCHEDULE FOR CASES

I Name of child

II Sex

III Age

IV Nationality

V Size of family

a. Position of the child in the family

VI Referring agency

VII Diagnosis at the time of referral

a. Prognosis at the time of referral

VIII Physical findings at the time of placement

IX Placement

a. Foster home group

b. Number in the group

c. Child's attitude toward placement

d. Child's participation in the group

e. Special interests and activities

f. Relation with other children

g. Special physical routine taught, if any

h. Length of placement

i. Attitude at end of placement

X Physical findings at end of placement

XI Follow-up visit

a. Evaluation of social changes, if any

XII Evaluation of physical changes, if any, by the referring agency

a. At the time of the next clinic visit

b. Permanent improvement as seen in clinic contacts throughout the school year following placement

XIII Previous history of rheumatic infection

a. Time of infection

b. Specialized care given

i Hospitalization - treatment given

ii Foster home care given - agency or other resource used

iii Care given at home

c. Attitude toward illness

d. Diagnosis at time of infection

e. Prognosis at the time of infection

XIV History of rheumatic infection following placement in 1938

a. Dates of recurrences

b. Specialized care given - agencies used

c. Diagnosis at time of recurrence

d. Prognosis at the time of recurrence

SCHEDULE FOR FOSTER HOMES

I Buildings used

- a. Name given to group

II Architectural plan of buildings

- a. Heating
- b. Toilet facilities
- c. Number of children per bedroom
- d. Dining facilities
- e. Indoor play space
- f. Special equipment used for the group

III Outdoor play space

- a. Special equipment

IV Foster mother

- a. Personality
- b. Special abilities as a group leader
- c. Previous experience in caring for rheumatic children

V Number of children in the group

- a. Number of children with rheumatic infection
- b. Physical condition of other children in the group, if any

VI Determination of special age groups

VII Daily program of the group

VIII Special activities

IX Religious opportunities

X Medical and dental facilities used by the children during placement

SCHEMES FOR FOSTER HOMES

I Buildings used

a. Home given to group

II Architectural plan of building

a. Heating
b. Toilet facilities
c. Number of children per bedroom
d. Dining facilities
e. Indoor play space
f. Special equipment used for the group

III Outdoor play space

a. Special equipment

IV Foster mother

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a. Number of children with rheumatic infection
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